LEGISLATIVE SERVICES AGENCY
OFFICE OF FISCAL AND MANAGEMENT ANALYSIS

301 State House
(317) 232-9855

FISCAL IMPACT STATEMENT

LS 7163 **DATE PREPARED:** Jan 11, 2002
BILL NUMBER: HB 1296 **BILL AMENDED:**

SUBJECT: Medicaid Liens and Services.

FISCAL ANALYST: Kathy Norris
PHONE NUMBER: 234-1360

FUNDS AFFECTED: X **GENERAL** **IMPACT:** State
DEDICATED
X **FEDERAL**

Summary of Legislation: This bill authorizes the Office of Medicaid Policy and Planning (OMPP) to: (1) place a lien on a Medicaid recipient's real property if OMPP determines that the recipient will not return to live in the property; and (2) enforce the lien if the property is sold or upon the death of the recipient. It provides certain exemptions. The bill permits OMPP to recover from a deceased Medicaid recipient nonprobate assets in which the recipient has an interest at death but that do not pass through the probate estate.

The bill also requires OMPP to apply for approval to: (1) amend the State Medicaid Plan to include personal care services; (2) amend the Aged and Disabled Waiver to modify income eligibility requirements to include spousal impoverishment protection provisions; and (3) apply for a Medicaid waiver to fund adult foster care. The bill further requires the Office of the Secretary of Family and Social Services (FSSA) to: (1) reduce the number of individuals on a waiting list compiled by the Area Agencies on Aging for services offered under the Community and Home Options to Institutional Care for the Elderly and Disabled (CHOICE) program before July 1, 2005; and (2) amend any Medicaid waiver for Home and Community-Based Services so that an eligible individual receives services within 90 days after being determined eligible for the services.

Effective Date: Upon passage; July 1, 2002; January 1, 2003.

Explanation of State Expenditures: ***Real Property Lien Provisions:*** This bill would authorize the Office of Medicaid Policy and Planning (OMPP) to place a lien for the cost of all Medicaid expenditures made on behalf of the recipient on a recipient's real property if a determination is made that the individual will not return to live in the property. OMPP is not authorized to seek or enforce a lien if the recipient's spouse, child, or sibling, are residing or continue to reside in the home under certain conditions. In the event that the Medicaid recipient returns to the home, OMPP is required to release the lien. OMPP estimates the improved ability to recover assets from recipient's estates will result in a savings to the program of $2.7 M, or approximately $1 M in state General Funds.

Recovery of Nonprobate Assets*:* The bill would also expand the type of assets that OMPP may seek recovery for the costs of a recipient's care. Current law limits the definition of the recipient's estate to the property and assets that are included in the probate estate. This definition excludes certain other types of property and assets that recipients may have legal title or an interest, such as life estates and other certain types of trusts. The transfer of assets to these nonprobate forms of ownership or interest are some of the common methods used to shield assets from the Medicaid eligibility determination and recovery processes. The extent to which assets are shielded from the state's recovery process is not known, but increased recoveries from individuals with resources available to help provide the cost of their care will result in savings to the state General Fund.

Personal Care as a Required Service under the State Plan: The bill requires an amendment to the State Medicaid Plan that would add personal care services to the list of services for which Medicaid recipients are individually entitled. Medicaid personal care services are defined as services provided to an individual who is not an inpatient or resident of a facility or institution that are authorized by a physician or a care plan approved by the state and that are provided by a qualified individual who is not a member of the individual's family. The extent to which this additional service would increase Medicaid cost would be dependent upon the service limits that the Secretary would define and how OMPP would revise all the Home and Community-Based Waiver programs. (A state cannot offer precisely the same service definition for the State Plan and a waiver since waiver participants are already entitled to State Plan services.) Typically, states that offer personal care services as a State Plan service, place strict limitations on the amount of services available or cap the dollar amounts of such services at a very low level.

Background: Federal law distinguishes between services offered under the State Medicaid plan and those that may be offered if the Secretary of Health and Human Services grants a waiver of certain federal requirements for alternative services. Services covered under the State Plan must be available on a comparable basis to all Medicaid beneficiaries in an eligibility group (such as the aged or the disabled) who require the service. That is, the State Plan cannot offer a service only to persons with a particular condition or offer varying amounts of service to different groups of individuals in an eligibility group. The service must also be available statewide; it cannot be restricted to a certain geographic region of the state.

When a state covers a service under its State Plan, it may impose limits on exactly what will be provided and under what circumstances. These limitations typically involve the amount of service, the duration that service can be provided, and the scope of service provided. These limitations generally must be based on clinical grounds and must be sufficient to meet the needs of most people most of the time. The decision to offer a service under the State Plan amounts to a decision to make the service available to all eligible individuals who require it within whatever limits the state establishes for the amount, duration, and scope the state may establish.

Generally, under the waiver authority, states can provide services not usually covered by the Medicaid program if these services are required to keep a person from being institutionalized. The current Indiana program provides for personal care services as a service provided under the definition of the various Home and Community-Based Waivers that the state operates. Waiver programs are not required to offer all services covered under the waiver to all potential beneficiaries in the state. Waivers are a way for states to target services to distinct groups of people (such as the developmentally disabled or the aged),while maintaining some ability to control the level of spending.

Application of Spousal Impoverishment Provisions to Aged and Disabled Waiver: This provision would expand the financial eligibility standards for the Aged and Disabled Waiver to be equivalent to the standards currently used to determine eligibility for nursing facility care. The fiscal impact on the state would be

anticipated to have two outcomes: 1) The waiver waiting list may expand due to increased eligibility standards applied with no additional funds for services; and/or 2) if individuals meeting the new spousal impoverishment income and asset standards are currently receiving CHOICE services were moved to the waiver program services and the 100% state CHOICE funding were used to leverage the federal Medicaid reimbursement (62% of total expenditures), more individuals could potentially be served on the Aged and Disabled waiver. The number of recipients who could be deinstitutionalized as a result of more liberal standards is not known nor is the number of current CHOICE recipients who might meet the more liberal eligibility standards to receive services under the waiver instead of CHOICE. This note will be updated if the information becomes available.

Background: Spousal impoverishment refers to the requirement that states allow married couples separated by the institutionalization of one spouse to protect a certain amount of income and assets for the use of the non-institutionalized spouse. Spousal impoverishment provisions are applicable in two circumstances: 1) residence of one spouse in a nursing facility; or 2) residence in the community under a waiver program. Currently, Indiana does not apply the spousal impoverishment standards to the Home and Community-Based Waiver.

Adult Foster Care Waiver: The bill would require OMPP to apply for a Medicaid waiver for Adult Foster Care Services before July 1, 2002. Adult Foster Care Services include personal care and services, homemaker, chore, attendant care, companion services, and medication oversight in a licensed private home by a principal care provider who lives in the home. Typically these living arrangements are made available to individuals with physical disabilities or who are elderly. The service definition allows states to pull all the services together into a single coverage rather than defining each service as a separate component.

The Division of Disability, Aging and Rehabilitative Services (DDARS) reports that while a waiver application has been prepared, there are no state rules in place defining the licensure requirements for adult foster care and the qualifications required for the providers.

Reduce CHOICE Waiting List: The bill would require the Secretary of the Family and Social Services Administration (FSSA) to eliminate the waiting list for the Community and Home Options to Institutional Care for the Elderly and Disabled (CHOICE) program before April 1, 2005. The bill further specifies that the Secretary may not reduce services or change the eligibility determination to achieve the waiting list reduction. The CHOICE waiting list was 9,384 as of June 30, 2001. The bill provides no additional appropriations for the CHOICE program.

The Secretary could expand the financial eligibility parameters of the Home and Community-Based Waivers, using the 100% state-funded CHOICE program appropriations to leverage federal Medicaid reimbursement and thereby attempt to eliminate the waiting list. The Medicaid Aged and Disabled Waiver currently has 2,330 individuals on the waiting list for services as well, so the total number of individuals seeking state-funded services for the aged and disabled is approximately 11,714. The average annual cost of Medicaid waiver services in FY 2000 was $9,759 per approved slot, or about $3,700 in state dollars. Using these assumptions, if the entire group of individuals were eligible under new waiver parameters, they would require services estimated to cost $114.4 M or $43.3 M in state General Funds. The FY 2003 appropriation for CHOICE is $48.6 M. Of the total appropriation, $4.9 M is already transferred to the Medicaid waiver program leaving a maximum of $43.7 M for the CHOICE program. This would leave a minimum remainder of $0.4 M available to provide services to the individuals with incomes or assets above the federally allowed limits or are younger than age 65 who still would not qualify for waiver services. (Note: The Secretary is also authorized to transfer up to $3 M to the Medicaid waiver in addition to the $4.9 M.) This shift to the waiver

program would also eliminate the flexibility of service provision and program definition that is a feature of the state-defined program.

Depending upon how the Secretary would expand the waiver eligibility, individuals that qualify for and receive the Medicaid waiver services also could qualify for all Medicaid benefits under the State Medicaid Plan. This additional cost to the state could potentially exceed the cost of the waiver services. Additionally, the waiting list is the result of the state's desire and ability to control costs while leveraging federal Medicaid dollars; it is not an accurate measure of the demand for state-supplied services. The demand for free services that currently are supplied by family or voluntary informal support systems is unknown.

The cost of this provision would ultimately depend upon how the Secretary would implement the reduction of the waiting list, whether by requesting more General Fund appropriations for CHOICE, expanding the Medicaid Aged and Disabled Waiver or some combination of both. The Secretary could also reduce the size of the "waiting list" simply by directing that if services are not immediately available, no applications will be taken, held, or maintained.

Require Waiver Service Provision Within 90 Days of Eligibility Determination: States are required to ensure that the Home and Community-Based Waiver Services are cost effective. The Centers for Medicare and Medicaid Services (CMS - formerly the Health Care Financing Administration, or HCFA) require that waiver and State Plan services provided to waiver recipients cost no more than the institutional setting for which the waiver services are the alternative. This cost-effectiveness measure has no caseload factor; however, the waiver cost is evaluated in terms of unduplicated beneficiary counts.

A state may limit the number of individuals who may receive benefits through the waiver program as a means of controlling cost, by specifying a maximum number of beneficiaries for each year the program is in operation. Once the specified maximum is reached, the state is permitted to deny enrollment to individuals and place them on a waiting list until waiver slots become available. A state may change the maximum number by notifying CMS at any time of the change.

This provision would essentially require that all waiver services be provided on the same basis as Medicaid State Plan services. (See the discussion above regarding personal care services.) The table below shows the average annual cost of each waiver as reported for FY 2000, along with the December 2001 waiting list counts. Using these assumptions, the group of individuals eligible to receive services within 90 days would require additional total funds of $197.5 M, or $75.1.M in State General Funds. This estimate assumes that there is no duplication between the waiting lists (anecdotal reports indicate there may be some duplication), and there is no inflation factor applied to the cost of service. Additionally this estimate assumes that the waiting list is an accurate measure of the demand for these services.

	Aged & Disabled	Autism	Medically Fragile Children	MR DD	Brain Injury	Total Additional Waiver $
Avg Annual Cost	9,759	28,073	12,728	46,764	14,202	
Dec. 2001 Waiting List	2,330	412	212	3,411	69	
Total Cost	22,739,309	11,565,944	2,698,421	159,510,367	979,908	197,493,949
State Medicaid Match	**8,640,937**	**4,395,059**	**1,025,400**	**60,613,939**	**372,365**	**75,047,700**
Federal Reimbursement	14,098,372	7,170,885	1,673,021	98,896,428	607,543	122,446,249

Explanation of State Revenues: Medicaid is a federal- and state-funded entitlement program. For every dollar spent on qualifying services in Indiana, the federal program reimburses the state 62%.

Explanation of Local Expenditures:

Explanation of Local Revenues: County Recorders are required to waive the filing fee for the filing of a release of a lien if a recipient returns to the home upon which OMPP filed a lien.

State Agencies Affected: Family and Social Services Administration, Office of Medicaid Policy and Planning, Division of Disability, Aging, and Rehabilitative Services.

Local Agencies Affected: County Recorders.

Information Sources: Amy Brown, Legislative Liaison for the Family and Social Services Administration, (317) 232-1149; Evelyn Murphy, Director, Long-Term Care Program, OMPP: Alison Becker, Assistant Director for Finance, DDARS; *Understanding Medicaid Home and Community Services: A Primer*, U.S. Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation, October 2000; *Statewide IN-Home Services FY 2000 Annual Report*, June 30, 2000, The Family and Social Services Administration.